

# **South Carolina Department of Disabilities and Special Needs**

## **PDD State Funded Program Acknowledgement of Rights and Responsibilities**

Name: \_\_\_\_\_

I acknowledge that this information is to assist me in understanding the Pervasive Developmental Disorder (PDD) State Funded Program services, my rights, my responsibilities, and my benefits. I will keep this information in a place where I can find it. I can contact my Service Coordinator/Early Interventionist at \_\_\_\_\_ if I have any questions or need assistance.

### **I. By receiving services through the Pervasive Developmental Disorder (PDD) State Funded Program:**

1. I have the right to be treated with dignity and respect by my Service Coordinator/Early Interventionist and all providers of my PDD State Funded services.
2. I have the right to confidentiality.
3. I have the right to receive a full explanation of all the forms that I am asked to sign.
4. I have the right to be told about all services available from SCDDSN.
5. I have the right to know the name of my Service Coordinator/Early Interventionist and how I can contact him or her during working hours.
6. I have the right to participate in the development of my single plan/IFSP/FSP, have my single plan/IFSP/FSP explained to me and have a copy provided.
7. I have the right to choose the agency or provider for each of my PDD State Funded Program services from all qualified/enrolled providers (a list for each PDD State Funded Program service is available online at [www.state.sc.us/ddsn/](http://www.state.sc.us/ddsn/)). My decision to receive services from a provider cannot be based on race, color, sex, religion or national origin.
8. I have the right to contact providers to evaluate service quality and gather information to assist in making an informed choice.
9. I have the right to change my provider by notifying my Service Coordinator/Early Interventionist.
10. I have the right to file an appeal if I disagree with any decision or action concerning my services or participation in the PDD State Funded Program.
11. I have the right to complain about services/providers by contacting my Service Coordinator/Early Interventionist.
12. I have the right to discontinue participation in the PDD State Funded Program by contacting my Service Coordinator/Early Interventionist.
13. I have the right to be informed about any potential risk associated with services in the PDD State Funded Program. I have the right to assume that risk and be responsible for any consequences.

14. I have the right to refuse to participate in a PDD State Funded Program service, but understand that I must receive a PDD State Funded Program service at least every thirty (30) days. If I do not receive a PDD State Funded Program service at least every thirty (30) days, I will be terminated from the PDD State Funded Program with written notification and appeals information.

## **II. As a PDD State Funded Program participant:**

1. I will treat my Service Coordinator/Early Interventionist and service providers in a considerate, respectful and courteous manner.
2. I will inform my Service Coordinator/Early Interventionist and all service providers in advance when I will be away from my home on dates of scheduled services/visits.
3. I will be present at the time of the provider's scheduled visits. This means I will be present at all team meetings and workshop sessions and must be trained in all therapeutic procedures and be an active contributor to my child's program to carry over and reinforce targeted behaviors and skill learning. I agree to meet with the Line Therapy supervisor weekly.
4. I will admit the service provider into my home.
5. I will not ask the service provider to perform tasks that are against the law or that are not a part of my single plan/IFSP/FSP.
6. I understand the PDD State Funded Program will not provide for all of my service needs.
7. I will follow the agreed upon single plan/IFSP/FSP.
8. I will provide accurate and complete information about:
  - past and present medical histories;
  - my family or others who can provide supports;
  - other services being provided to me;
  - changes in my condition or situation, i.e. hospitalization, additional caregiver(s), income, and other events impacting my care;
  - changes in my address, phone number(s) and persons assisting me with my care; and
  - timekeeping records that I may be required to sign in regards Early Intensive Behavioral Intervention services.
9. I understand that the PDD State Funded Program and DDSN do not provide emergency care. In case of medical emergency, I must contact my physician, go to the hospital or call 911.
10. I understand that I must be available for and participate in my annual plan meeting and that not participating may lead to the suspension of my waiver services.

I understand that not abiding by the rights and responsibilities indicated in this document may lead to the termination of wavier services.

---

Signature of Parent/Legal Guardian

---

Date

---

Signature of Service Coordinator/Early Interventionist

---

Date